This is Exhibit # 2
In CONO vs. Kurt Stauffert
(DC21-03) Date: October 11, 2022

DISCIPLINE COMMITTEE OF
THE COLLEGE OF NATUROPATHS OF ONTARIO

B E T W E E N:

COLLEGE OF NATUROPATHS OF ONTARIO

and

KURT STAUFFERT

AGREED STATEMENT OF FACTS AND ADMISSION OF PROFESSIONAL MISCONDUCT

The parties hereby agree that the following facts and attachments may be accepted as true by the Discipline Committee of the College of Naturopaths of Ontario:

The Registrant

1. Kurt Stauffert (the "Registrant") was a registrant of the College of Naturopaths of Ontario (the "College") at all relevant times. The Registrant first became registered with the Board of Directors of Drugless Therapy (Naturopathy) on or about April 7, 2004. Attached at **Tab "A"** is a printout from the College's Naturopathic Doctor Register.

2. At all relevant times, the Registrant worked at EcoClinic for Integrative Healthcare located in Barrie, Ontario.

The Patient

3. The College received a complaint on October 16, 2020 from the daughter of the Registrant's former patient (the "Patient").

4. The Patient became a patient of the Registrant on or about December 17, 2016. The Patient attended regular appointments with the Registrant over the next four years. She ceased being a patient of the Registrant in September, 2020.

Cancer Diagnosis and Subsequent Attendances before the Registrant

5. On September 30, 2018, the Patient emailed the Registrant and advised him that she had recently had a mammogram which showed a lump on her right breast. She further advised that she was scheduled to have a biopsy on October 1, 2018, and requested to book an appointment with the Registrant "to discuss the problem and treatment".

6. On October 10, 2018, the Patient visited the Registrant at which time she advised the Registrant that she had undergone the biopsy of her right breast as a result of a lump found by her medical provider. At that time, according to the Registrant's patient record, he prescribed Gemmo #1 botanical to "induce sleep, improve immune function especially in the right breast". He also prescribed Gemmo #2 to "eliminate the larvicide temephos from the superior vena cava, the vocal chords and the sphincter of oddi". The Registrant made a further note in the record that he told the Patient to "call us with results of biopsy and consider reassessment of status after returning from B.C.", where the Patient was scheduled to be travelling for 10 days.

7. The Patient was subsequently diagnosed with breast cancer by Dr. Monica Chaudhuri, based on the results of the Patient's biopsy. The patient record shows that the Patient advised the Registrant of her diagnosis and provided him with a copy of the Surgical Pathology Final Report in relation to her biopsy on October 15, 2018.

8. On November 13, 2018, the Patient attended before the Registrant to discuss her diagnosis. If the Patient were to testify, she would state that the Registrant told her that he could control and treat her cancer. She would also state that the Registrant told her he did not believe in chemotherapy, which he said was poison and killed people.

9. At the November 13, 2018 appointment, the Registrant prescribed a botanical "to regenerate the nerves in the right breast and right pleural cavity and improve sleep". The Registrant made a note in the chart that the Patient's family was "not very supportive of her choices for alt health care". He further noted that he advised the Patient he could "continue/assist with monitoring progress to help her decisioning". The Registrant also noted that "after botanical consider additional imaging to reassess cancer in right breast".

10. The records of the November 13, 2018 appointment also show that the Registrant noted that they should "consider a biomarker of Breast cancer CA-15". Cancer Antigen ("CA") 15-3 is a protein made by breast cancer cells. In general, the higher the level of CA 15-3 in the blood, the more cancer there is in the body. CA 15-3 levels are monitored in order to ascertain a patient's response to breast cancer treatment and disease recurrence.

11. After her breast cancer diagnosis, the Registrant ordered numerous tests for the Patient, including CA 15-3 levels, Psychosomatic Energetics testing ("PSE") testing[1], urine testing and complete blood count ("CBC") testing. If the Patient were to testify, she would state that she was not certain what the blood tests the Registrant was ordering were for, however she trusted the Registrant's judgment and the treatment he was providing.

12. The Patient attended numerous appointments with the Registrant between October 2018 and September 2020. If the Patient were to testify, she would state that the Registrant

[1] PSE testing involves the use of a test device to quantitatively test a patient's subtle-energy system.

would repeatedly tell her that the treatment was working and her cancer was not metastasizing. Moreover, if the Patient were to testify, she would state that she believed the Registrant was treating her breast cancer and that the treatments he was providing and substances he was prescribing were for the purpose of treating her breast cancer.

13. For example, at an appointment on December 4, 2018, the Registrant prescribed Gemmo #5 to "eliminate CWD staph bacteria from the R. breast milk ducts and the lyme co-infector" and noted same in her chart. He also made a note that the patient reported that the tumor in the Patient's right breast was less than 2 cm and "seems to be moving out to the surface".

14. At a February 4, 2019 appointment, the Registrant made a note that the Patient reported that her right breast nipple was leaking watery blood and is tender. He also noted that the patient reported that the "lump is unchanged in size". His assessment included "prescriptions to support breast health and other tissue health", which in turn included a T"botanical to regenerate nerves in the r. breast …" and Gemmo #9 to "eliminate sclerotic scar tissue in the R. Breast … and to eliminate … parasite … from the R. and L. Breast".

15. The Registrant also continued to recommend further testing, including PSE testing and a urine test, and made a note in the chart that he requested a copy of the Patient's mammogram and ultrasound of her right breast. At a March 8, 2019 appointment, he again requested that the Patient complete a CBC test and a CA 15-3 test and made a note of this in the Patient's chart. If the Patient were to testify, she would state that the Registrant would order a lot of blood tests for her, but she was not sure what they were for.

16. The Registrant made a note regarding an April 5, 2019 appointment with the Patient where he stated "more issues resonating in R and L Breast. Suspected pesticide, scar tissue, emotion conflicts". He continued to order additional tests for the Patient, including CA 15-3 tests and fecal occult blood tests, and recommended that she continue to attend before him for monitoring.

17. Seven months after her cancer diagnosis, the Patient developed a wound on her right breast. If the Patient were to testify, she would state that when she showed the blister to the Registrant he stated that it was good as the cancer or "poison" was coming out. In addition, she would state that the Registrant would prescribe many tinctures for her breast, that she was not sure what they were but that she trusted the Registrant's judgment and the treatment he was providing.

18. At a July 23, 2019 appointment, the Registrant noted that laboratory results showed that the Patient's CA 15-3 levels were down "10% since last check", and that the Patient's reported that her breast was "weeping constantly". As had become his practice, the Registrant conducted PSE Testing and sent the Patient for further blood draws for CA 15-3 monitoring. The Registrant made a note that the Patient was to follow up "ASAP".

19. At a September 27, 2019 appointment the Registrant noted that the Patient's CA-15 levels were "gradually rising", and wrote in her chart that the Patient was "ok to keep monitoring". He ordered further blood tests, including CBCs and CA 15-3.

20. It is admitted that the Registrant's conduct in the time following her cancer diagnosis may have created confusion in the Patient and may have led her to believe he was treating her cancer. It is further admitted that the Registrant knew or ought to have known that the

treatments he was recommending were ineffective against cancer.

21. It is admitted that the Registrant may have failed to effectively communicate with the Patient and adequately explain the purpose of the tests he was ordering, as detailed above.

22. Throughout his treatment of the Patient, the Registrant never communicated with the Patient's health care practitioners about the Patient's cancer, its symptoms or lab results he obtained from the tests he was ordering. When the Registrant received a report in 2017 that showed palpable abnormalities in the left and right breast which were characterized as clinical findings, he failed to ensure this was communicated to the Patient's family doctor, nor did he proactively communicate with them despite knowing that they were involved in her care.

Practising Outside the Scope of a Naturopath

23. It is admitted that the Registrant provided services that he did not have the knowledge, skill or judgment to perform. In addition to the above, in or around February, 2017, and prior to the Patient's cancer diagnosis, the Registrant recommended to the Patient that she obtain a breast ultrasound from a specific clinic. If the Patient were to testify, she would state that the Registrant told her that this ultrasound was "better than a mammogram", and that he was "enthusiastic" about its efficacy. As noted above, when the ultrasound report indicated a critical value test result, he did not share the results with the Patient's family doctor.

24. It is admitted that the Registrant is required to refer a patient to a member of the College of Physicians and Surgeons of Ontario or a member of the College of Nurses who holds a certificate of registration as a registered nurse in the extended class when laboratory tests indicate a critical value test result.

25. Also in 2017, in response to the Patient advising the Registrant that she had been diagnosed with a kidney infection, the Registrant prescribed Berberis Formula, which he stated "might be sufficient to avoid antibiotics".

26. It is admitted that the Registrant was not fully aware that increased INR levels could indicated that the patient's cancer had metastasized. but the tests were ordered to determine if the remedies provided to the Patient had an affect on blood clotting, which was the purpose of the INR test and did not ask the Patient if he could send the results to her family physician.

27. The Patient had been prescribed Warfarin by her family physician due to a previous blood clot in her lung. Warfarin is an anti-coagulant prescribed to help prevent blood clots, and patients taking Warfarin require continuous monitoring of INR as it can have serious side effects, including bleeding.

28. Notwithstanding it having been prescribed by her family physician, the Registrant routinely questioned whether Warfarin was appropriate. For example, in a February 12, 2018 email, the Registrant stated that as her health improved the Patient might "need Warfarin less and less", however if she were to stay on Warfarin it "may lead to negative consequences". In a June 14, 2018 note, the Registrant recorded that the Patient was suffering from vertigo. The Registrant writes "we assess that it is due to warfarin toxicity" and queries whether the Patient can cease Warfarin. His record for that date also includes an article which

discusses alternative blood thinners and a handwritten note "maybe causing issues with bones (thoracic + lumbar spine CT 2012 degenerated) and immunity as Warfarin blocks K2".

29. In a July 14, 2020 note, the Registrant raised concerns about recent lab results and noted that he wondered "if it's only possibly cancer or if Warfarin (long term)" is involved. In an August 11, 2020 note, the Registrant recorded that the Patient's INR levels as increasing. The Registrant questioned why the INR levels were running "so high" and wrote a note "too much Warfarin?". Similarly, in a September 4, 2020 note summarizing a discussion he had with the Patient, the Registrant noted that the Patient's physician recommended a CT scan to investigate her back pain, which might be "part of the cancer scene". The Registrant notes, however, that the pain could also be the result of "old trauma, osteo, low K2 or Warfarin".

30. The Patient's health steadily deteriorated between October 2018 and September 2020. Her final appointment with the Registrant was in September, 2020. The Patient attended hospital on September 10, 2020 and learned that her cancer had metastasized to the bone. If the Patient were to testify, she would state that doctors told her that she had weeks to live.

31. It is admitted that, in the face of clear evidence that the Patient's condition was worsening and that the treatment he was providing was not adequate, effective or likely to improve her cancer. The Registrant did not refer, or discuss a referral, of the Patient's care to a to a doctor with the appropriate knowledge, skill and judgment to treat the Patient. The Registrant ought to have known that the Patient required a service that he did not have the knowledge, skill or judgment to offer and was beyond the scope of his practice.

32. If the Patient were to testify, she would state that the Registrant did not ask her if he could communicate with her family physician or oncologist, or any other health care practitioner in her circle of care.

Record-Keeping

33. It is admitted that the Registrant failed to maintain a complete record for the Patient and failed to maintain appropriate records. The Patient's chart did not contain adequate treatment notes. Rather, the Registrant resorted to writing brief comments on sticky notes, which were present throughout the Patient's chart.

34. It is admitted that the Registrant did not maintain a contemporaneous record for the Patient and often supplemented the record after the fact using the sticky notes. It is further admitted that the Registrant did not obtain and/or document the consent process with the Patient in the record, nor did the Registrant document a naturopathic diagnosis for the Patient.

35. During the College's investigation of the complaint, the Registrant sent records to the College's investigator in December, 2020. Later, in July, 2021, the College's investigator obtained the original records. The original records differed from the records that were provided by the Registrant in December, 2020. Specifically, the Registrant added information to the record prior to providing it to the College, including altering telephone logs and adding new entries to notes addressing the Patient's various appointments. It was also discovered that the Registrant had added handwritten notes to laboratory tests,

including a note that the Patient should share test results with her medical doctor, which note was not present in the original record.

36. It is admitted that the Registrant added additional information to the Patient's record during the College's investigation without indicating in the record that he had made amendments thereto. It is further admitted that the Registrant falsified the Patient's records in the face of a College investigation into his conduct.

Consent

37. It is admitted that the Registrant failed to obtain consent for all treatments. The Patient signed a general consent form when she first attended before the Registrant in or around December, 2016. This general form did not amount to informed consent. If the Patient were to testify, she would state that no further discussions regarding consent to treatment took place thereafter. Nor is there any documentation regarding consent to treatment in the Patient's record.

38. It is further admitted that, towards the end of the period in which he was treating her, the Registrant improperly attempted to have the Patient sign a special consent form to protect him from her family.

Boundaries and Conflict of Interest

39. If the Patient were to testify, she would state that she refused chemotherapy when it was recommended to her by her medical doctor as she felt that she was under the Registrant's care, and that he was taking care of her cancer. She would further testify that she trusted the Registrant, though she did not always understand the nature or purpose of the treatments he was recommending or the tests he was ordering.

40. It is admitted that the Registrant failed to recognize the influence he wielded over the Patient and failed to foster an appropriate therapeutic relationship with the Patient in a transparent and patient-centered manner.

41. It is further admitted that the Registrant used his influence over the Patient to encourage her to sign a special consent form to protect him from her family, whom he assumed would have serious concerns that he provided care to the Patient rather than encouraging her to seek appropriate care for her breast cancer. This letter was never written nor signed.

Core Competencies and Code of Ethics

42. As detailed above the Registrant failed to formulate a naturopathic diagnosis, failed to develop and maintain relationships with other healthcare professionals in the care of the Patient and failed to effectively communicate with the Patient. He further failed to ensure the Patient was fully knowledgeable regarding the treatment he was providing. If the Patient were to testify, she would state that she did not always understand what the Registrant was prescribing for her, the treatment options he recommended or the tests he was requiring that she complete, but she trusted him.

43. It is admitted that the Registrant knew or ought to have known that the Patient required a service that he did not have the knowledge, skill or judgment to offer and was beyond the

scope of his practice. Moreover, the Registrant failed to provide the Patient with the information she needed to make informed decisions about her care.

44. The Registrant failed to practice only within the limits of his professional competence, thereby compromising the quality of care provided to the Patient.

Standards and Guidelines of the College

45. During the relevant periods of time, it is agreed that the following written standards and guidelines applied to the Registrant (all of which are attached at **Tab "B"**):

    a) Core Competencies;

    b) Code of Ethics;

    c) Consent;

    d) Record Keeping;

    e) Scope of Practice; and

    f) Therapeutic Relationships and Professional Boundaries.

Admissions of Professional Misconduct

46. It is agreed that the above-noted conduct constitutes professional misconduct pursuant to section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991* (the "Code") as set out in one or more of the following paragraphs of section 1 of Ontario Regulation 17/14 made under the *Naturopathy Act, 2007*:

    a) **Paragraph 1**. Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession including but not limited to the following;

        i. Record Keeping;

        ii. Core Competencies;

        iii. Conflict of Interest;

        iv. Code of Ethics;

        v. Consent;

        vi. Scope of Practice;

        vii. Therapeutic Relationships and Professional Boundaries;

        viii. Requisitioning Laboratory Tests; and

ix. 13 (3) of the Ontario Regulation 168/15 (the "General Regulation");

b) **Paragraph 3.** Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic or other health-related purpose except,

   i. with the informed consent of the patient or the patient's authorized representative, or

   ii. as required or authorized by law;

c) **Paragraph 7.** Recommending or providing treatment that the member knows or ought to know is unnecessary or ineffective;

d) **Paragraph 8**. Providing or attempting to provide services or treatment that the member knows or ought to know to be beyond the member's knowledge, skill or judgment;

e) **Paragraph 9.** Failing to advise a patient or the patient's authorized representative to consult another member of a health profession within the meaning of the *Regulated Health Professions Act, 1991*, when the member knows or ought to know that the patient requires a service that the member does not have the knowledge, skill or judgment to offer or is beyond his or her scope of practice;

f) **Paragraph 14.** Prescribing, dispensing, compounding or selling a drug or a substance for an improper purpose;

g) **Paragraph 36.** Contravening, by act or omission, a provision of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts, including but not limited to sections 13(3) of the General Regulation;

h) **Paragraph 23**. Failing to keep records in accordance with the standards of the profession;

i) **Paragraph 25**. Falsifying a record relating to the member's practice;

j) **Paragraph 46**. Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional;

k) **Paragraph 47.** Engaging in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession and

l) **Paragraph 48.** Failing to make reasonable attempts to collaborate with the patient's other relevant health care providers respecting the care of the patient, where such collaboration is necessary for the patient's health, unless the patient refuses to consent.

Acknowledgements

47. By this document, the Registrant states that:

a) He understands fully the nature of the allegations made against him;

b) He has no questions with respect to the allegations against him;

c) He admits to the truth of the facts contained in this document and that the facts constitute professional misconduct;

d) He understands that by signing this document he is consenting to the evidence as set out in this document being presented to the Discipline Committee;

e) He understands that by admitting the allegations made against him, he is waiving his right to require the College to prove the allegations against him at a contested hearing;

f) He understands that the decision of the Committee and a summary of its reasons, including reference to his name, will be published in the College's annual report and any other publication or website of the College;

g) He understands that any agreement between him and the College with respect to the penalty proposed does not bind the Discipline Committee ; and

h) He understands and acknowledges that he is executing this document voluntarily, unequivocally, free of duress, and free of bribe and that he has been advised of his right to seek legal advice.

All of which is respectfully submitted:

8/29/2022

Signed this ____ day of _____, 2022

DocuSigned by:
Kurt Stauffert
84E02D0C63B24D3...

Kurt Stauffert
Registrant

Signed this _31_ day of _August_, 2022

Andrew Parr, CAE
Chief Executive Officer
College of Naturopaths of Ontario

TAB A

College of Naturopaths of Ontario

Status as of: 28-Mar-2022 15:09
NOT A PRACTICE PERMIT

Dr. Kurt Heinrich Stauffert, ND

Registrant Number: 1223
Initial registration: 07-Apr-2004 (Initial Registration with the BDDT-N)
Nickname / abbreviation: N/A
Previous name: N/A

Current Registration

Class
General
Effective
01-Apr-2021

Status
In Good Standing
Expiry
31-Mar-2022

Extended Services

Service	Effective	Expiry	Notes
Intravenous Infusion Therapy (IVIT)		01-Jan-2016	Effective January 1, 2016 the Registrant is not authorized to administer a substance by intravenous infusion therapy or compound a substance for the purposes of administration by intravenous infusion therapy.

ICRC Referrals

Referred To: Discipline Committee
Referral Date: December 8, 2021
Hearing Date: TBD

Notice of Hearing

STATEMENT OF SPECIFIED ALLEGATIONS

The Registrant

1. Dr. Kurt Stauffert, ND (the "Registrant") registered with the Board of Directors of Drugless Therapy – Naturopathy on or about April 7, 2004. The Registrant then became registered with the College of Naturopaths of Ontario (the "College") on July 1, 2015.

2. At all relevant times, the Registrant worked at and/or owned EcoClinic for Integrative Healthcare in Barrie, ON (the "Clinic").

The Patient

3. On or about December 17, 2016, the Patient became a patient of the Registrant.

4. On or about October 2018, the Patient advised the Registrant that they had been diagnosed with breast cancer.

5. It is alleged that the Registrant:

a. Communicated to the Patient that they could treat cancer;
b. Permitted the Patient to believe that they could treat cancer so that it would not progress or words to that effect;
c. Did not provide the Patient with sufficient information so that they could make valid decisions about their care;
d. Dissuaded the Patient from taking Western and/or allopathic medicine to treat the cancer;
e. Ordered tests for the Patient to treat their cancer and/or to infer that they were treating the cancer and/or that they knew or ought to have known were unnecessary or ineffective;
f. Recommended that the Patient attend their Clinic regularly for testing and/or unnecessary testing;
g. Communicated to the Patient that the cancer was under control or words to that effect;
h. Provided false and/or misleading information to the Patient about the efficacy of the ordered tests and/or products that they prescribed and/or compounded and/or sold;
i. Ordered tests and/or communicated information to the Patient on issues that were not within their scope of practice;
j. Ordered a breast ultrasound for the Patient;
k. Recommended a supplement to the Patient in order to "avoid antibiotics" for a kidney infection diagnosed by a physician;
l. Requested information from the Patient's family physician and/or oncologist about the Patient's cancer and/or lab results;
m. Prescribed and/or compounded and/or sold products to the Patient to treat their cancer and/or to infer that they were treating the cancer and/or that they knew or ought to have known were unnecessary or ineffective;
n. Advised the Patient that a wound on their breast was the poison coming out of them or words to that effect;
o. Did not communicate with the Patient's family physician and/or oncologist and/or other relevant health care practitioner about the Patient's cancer and/or symptoms and/or lab results and/or did not ask the Patient if they could communicate with same;
p. Did not refer and/or discuss a referral with the Patient when the treatment was not adequate and/or not likely to improve and/or when the Registrant knew or ought to have known that the Patient required a service that the Registrant did not have the knowledge, skill or judgment to offer or was beyond their scope of practice;
q. Discussed having the Patient sign a special consent form to protect them from the Patient's family;
r. Did not maintain contemporaneous records for the Patient;
s. Did not obtain informed consent for all treatments;
t. Did not document the consent process with the Patient;
u. Did not communicate all discussions with the Patient related to patient care;
v. Falsified information in the Patient's record; and/or
w. Did not form and/or did not document a naturopathic diagnosis for the Patient.

6. It is also alleged that the Registrant;

a. Added additional information to the Patient's record during the College investigation;
b. Did not indicate in the Patient record that they had made amendments; and/or
c. Falsified information in the Patient's record during the College investigation.

Allegations of Professional Misconduct

7. It is alleged that the above noted conduct constitutes professional misconduct pursuant to section 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991* (the "Code") as set out in one or more of the following paragraphs of section 1 of Ontario Regulation 17/14 made under the *Naturopathy Act, 2007*:

a. **Paragraph 1**. Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession including but not limited to the following;
   i. Record Keeping;
   ii. Core Competencies;
   iii. Conflict of Interest;
   iv. Code of Ethics;
   v. Consent;
   vi. Scope of Practice;
   vii. Therapeutic Relationships and Professional Boundaries; and/or
   viii. Requisitioning Laboratory Tests;

b. **Paragraph 3.** Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic or other health-related purpose except,
   i. with the informed consent of the patient or the patient's authorized representative, or
   ii. as required or authorized by law;

c. **Paragraph 7.** Recommending or providing treatment that the member knows or ought to know is unnecessary or ineffective;

d. **Paragraph 8**. Providing or attempting to provide services or treatment that the member knows or ought to know to be beyond the member's knowledge, skill or judgment;

e. **Paragraph 9.** Failing to advise a patient or the patient's authorized representative to consult another member of a health profession within the meaning of the *Regulated Health Professions Act, 1991*, when the member knows or ought to know that the patient requires a service that the member does not have the knowledge, skill or judgment to offer or is beyond his or her scope of practice;

f. **Paragraph 14.** Prescribing, dispensing, compounding or selling a drug or a substance for an improper purpose;

g. **Paragraph 36.** Contravening, by act or omission, a provision of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts;

h. **Paragraph 23**. Failing to keep records in accordance with the standards of the profession;

i. **Paragraph 25**. Falsifying a record relating to the member's practice;

j. **Paragraph 46**. Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional;

k. **Paragraph 47.** Engaging in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession and/or

l. **Paragraph 48.** Failing to make reasonable attempts to collaborate with the patient's other relevant health care providers respecting the care of the patient, where such collaboration is necessary for the patient's health, unless the patient refuses to consent.

Show: Registration History | Employment

TAB B

The College of Naturopaths of Ontario

Core Competencies

Introduction

Naturopathic Doctors provide primary and adjunctive health care to people of all ages, focusing on the use of natural therapies to support and stimulate healing processes. Naturopathic Doctors promote health and prevent illness, and diagnose and treat disease in a manner consistent with the body of knowledge and standards of practice for the profession.

The following Core Competencies articulate the knowledge, skill and judgment required of Naturopathic Doctors at entry-to-practice.

Naturopathic Medical Knowledge

The competent Naturopathic Doctor:

1. Integrates naturopathic philosophy, theory and principles with naturopathic medical knowledge in the care of patients and case management including the assessment, diagnostic and treatment phases.

- Evaluates and integrates clinical arts and science knowledge within the context of naturopathic principles and philosophy in clinical practice.
- Formulates diagnoses and treatment plans consistent with naturopathic philosophy and principles.

2. Develops, maintains and respects a comprehensive naturopathic medical knowledge base.

- Demonstrates knowledge of the history and philosophy of Naturopathic Medicine.
- Demonstrates knowledge of the clinical arts and sciences essential to the practice of Naturopathic Medicine.
- Demonstrates knowledge of the theory and practice of therapeutics including botanical medicine, homeopathic medicine, traditional Chinese medicine and acupuncture, physical medicine, clinical nutrition, and lifestyle counselling.
- Updates knowledge base continuously through the review of relevant research and ongoing continuing education.

3. Conducts an assessment to formulate a diagnosis.

- Gathers information necessary to formulate a diagnosis.
- Incorporates knowledge of the determinants of health and disease into assessment.
- Formulates diagnoses based on a clinical assessment including but not limited to a medical history, physical examination and diagnostic testing.

4. Critically evaluates medical information.

- Understands, respects and incorporates evidence-based medicine1 in his/her practice.
- Appraises evidence critically to address clinical questions.

- Integrates new information appropriately into clinical reasoning.
- Evaluates and reflects on patient outcomes.

Inter-professional Practice and Collaboration

The competent Naturopathic Doctor:

1. Develops and maintains relationships with other health care professionals in the care of his/her patients.

- Demonstrates an understanding of the scope of practice of other health care professionals.
- Collaborates with others to support health promotion and disease prevention.
- Utilizes community resources in professional practice.
- Collaborates with other health care professionals in the care of his/her patients when necessary.

Communication

The competent Naturopathic Doctor:

1. Communicates effectively.

- Articulates information clearly and concisely and in a timely manner, listens actively and responds appropriately.
- Communicates appropriately with patients or their authorized representatives, colleagues, other health professionals, the community, his/her regulator, and other legal authorities.
- Requests from and provides to other health care professionals relevant patient information.
- Advances naturopathic principles and philosophy in communication with patients, health care professionals and the public.
- Maintains patients confidentiality and privacy.

Patient Care and Health Promotion

The competent Naturopathic Doctor:

1. Exemplifies the principle of doctor as teacher in patient interactions.

- Teaches the principles of healthy living and preventative medicine.
- Educates the patient regarding the etiology and development of disease.
- Educates the patient about the contributing factors to disease and dysfunction and the ways in which they impact health.
- Educates the patient about treatment options and their potential risks, benefits, and side effects.

2. Provides safe and effective patient care.

- Provides compassionate, ethical, effective and safe care.
- Utilizes naturopathic therapeutics effectively including botanical medicine, homeopathic medicine, traditional Chinese medicine and acupuncture, physical medicine, clinical nutrition and lifestyle counselling.
- Identifies and assesses the actions of and interactions between drugs, substances and therapies being used by or provided to the patient.
- Communicates a diagnosis.
- Creates, implements, monitors and revises effective individualized treatment plans.
- Documents patient care.

- Refers to other health care professionals when indicated.
- Engages patients in establishing a long-term strategy for their personal health.
- Maintains professional boundaries and refrains from conflicts of interest.

3. Promotes the principles and philosophy of Naturopathic Medicine to patients and the community.

- Promotes naturopathic principles and philosophy.
- Promotes sustainable health practices.
- Educates others on the significance of environmental factors on health.
- Promotes a wider acceptance of Naturopathic Medicine in the health care system.

Practice Management

The competent Naturopathic Doctor:

1. Establishes, develops and manages his/her practice.

- Practices in a compassionate, ethical and legal manner.
- Engages in short and long term business planning.
- Organizes and manages systems and resources relevant to practice needs.
- Maintains a safe and secure workplace.
- Manages time effectively.
- Recognizes the importance of establishing and maintaining a personal/professional life balance.

Education and Learning

The competent Naturopathic Doctor:

1. Ensures professional competence through ongoing self-assessment and professional development.

- Integrates learning into practice.
- Recognizes limitations in knowledge, skill, judgment and scope of practice.
- Engages in on-going professional development and learning.
- Understands the significance of research with respect to predicting health outcomes.
- References and employs empirical, literary and information-technology sources.
- Self-assesses professional knowledge and skills regularly.

2. Supports the advancement of Naturopathic Medicine through the development, critical assessment and dissemination of research and information.

- Participates in research activities as appropriate for professional practice.

3. Supports the mentorship of students and Members.

- Participates in mentorship as appropriate.

Legislation/Ethics

The competent Naturopathic Doctor:

1. Complies with all relevant laws and regulation.

- Complies with federal, provincial, and municipal legislation, regulations and bylaws.

• Understands and complies with the *Regulated health Professions Act, Naturopathy Act* and all College regulations and standards of practice.
2. Demonstrates ethical conduct and integrity in professional practice and personal conduct. • Practices with integrity and without prejudice. • Abides by the naturopathic oath. • Demonstrates accountability for practice decisions. • Places the protection of the public ahead of self-interest.

The College of Naturopaths of Ontario

Code of Ethics

Naturopathic Doctors have an obligation to act in a manner that justifies public trust and confidence, that upholds and enhances the integrity of the profession, that serves the interests of society and above all, that safeguards the interests of the individual patients.

The Code of Ethics defines the expectations the College of Naturopaths of Ontario has for every Registrant and is intended to guide naturopathic practice and assist in ethical decision making. The Code of Ethics, along with the Standards of Practice, forms the foundation of professionalism and Registrants adhere not only to these guidelines, but also to the underlying principles of Naturopathic Medicine.

General

Every Naturopathic Doctor shall:

- Practise competently, with integrity, and without impairment.
- Strive for professional excellence by advancing professional knowledge through lifelong learning.
- Practise only within the limits of professional competence, in surroundings that do not compromise the quality of care offered.
- Refuse any influence or interference that could undermine professional integrity. Refuse to participate in or support practices that violate basic human rights.

To the Patient

Every Naturopathic Doctor shall:

- Practise in a manner that treats each patient with dignity and respect.
- Provide care that respects the patient's needs, values and dignity, and does not discriminate on any grounds, including on the basis of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability. This does not negate the ND's right to refuse to accept a patient for legitimate reasons.
- Recommend only diagnostic procedures and treatments that he/she determines to be necessary for the well-being of the patient.

- Be considerate of the concerns of the patient's family and cooperate with them as appropriate in the patient's interest.
- Recognize and disclose conflicts of interest that arise in the course of professional duties and activities, and resolve them in the best interest of the patient.
- Refrain from treating an individual where the Registrant's professional objectivity may be compromised.
- Recognize professional limitations. When indicated recommend to the patient that additional opinions and/or services be obtained and provide referrals where possible.
- Recognize the patient's right to accept or reject any health care recommended.
- Safeguard the patient's right to privacy and only disclose confidential information when either authorized by the patient or required to do so by law.
- Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.
- Provide the patient with the information they need to make informed decisions about their care, and answer questions appropriately.
- Respect the patient's request for a second opinion.
- Continue to provide services to the patient until they are no longer required or wanted; until another suitable practitioner has assumed responsibility; or until reasonable notice of termination of care has been provided to the patient.
- Participate only in research that is scientifically relevant and conducted ethically and is approved by a research ethics board where appropriate.
- Recognize that community, society and the environment are important factors in the health of individual patients.

To the Profession

Every Naturopathic Doctor shall:

- Recognize that self-regulation of the profession is a privilege and that each Naturopathic Doctor has an ongoing responsibility to merit the retention of that privilege.
- Maintain and advance the standards of care, and body of knowledge and strive to improve professional knowledge, skill and judgment.
- Behave in a manner that is beyond reproach.
- Enter into associations, contracts and agreements only if they allow for professional integrity to be maintained.
- Rely on ability and integrity to build a professional reputation. Refrain from endorsing any service or product for personal gain.
- Collaborate with other Naturopathic Doctors and health professionals in the care of patients and in the function and improvement of the health care system.
- Refrain from keeping secrets from colleagues related to the diagnostic or therapeutic agents and procedures that are employed.
- Treat colleagues with dignity and respect.

To Society

Every Naturopathic Doctor shall:

- Consider the well-being of society in matters affecting health.
- Strive to improve the standards of health care and promote health and safety for the individual, the public and the global community.

- Recognize the profession's responsibility to society in matters relating to the health and well- being of the community.
- Recognize the responsibility to indicate when a stated opinion is contrary to the generally held opinion of the profession.
- Recognize and manage the impact of his/her naturopathic practice on public health care resources.
- Understand and minimize the impact of his/her naturopathic practice on the environment.

To the College of Naturopaths of Ontario

Every Naturopathic Doctor shall:

- Comply with all governing legislation, Standards of Practice, policies, by-laws and guidelines approved by the College of Naturopaths of Ontario.
- Report to the College any conduct of a colleague which may generally be considered unprofessional or unbecoming to the profession.
- Cooperate with and assist the College in its work.

To Oneself

Every Naturopathic Doctor shall:

- Strive to maintain personal health and well-being.
- Recognize those stress factors in professional and personal life that can affect patient care and incorporate appropriate coping strategies.
- Seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect service to patients, society or the profession.

The College of Naturopaths of Ontario

Standard of Practice:

Consent

Introduction

The intent of this standard is to inform Members of their obligations with respect to consent.

Definitions

Capacity: a person is deemed capable with respect to an intervention/decision if the person is able to understand the information relevant to making a decision about the intervention, and able to appreciate the reasonably foreseeable consequences of a decision, or lack of decision. People:

- are presumed capable unless there is information to lead the Member to think otherwise;
- may be capable with respect to one intervention/decision but not another;
- may be capable with respect to an intervention/decision at one time and incapable at another.

Consent: to acquiesce, agree, approve, assent and give permission to some act or purpose.

Consent and Capacity Board: an independent agency that deals with disputes over treatment decisions where a patient has been deemed not to be capable.

Informed Consent: a phrase used in law to indicate that the consent given by a person has been based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action. In order to give informed consent, the individual concerned must have adequate reasoning faculties and be in possession of all relevant facts at the time consent is given.

Substitute Decision-maker: a person who makes decisions for someone who is incapable of making his/her own decisions, and who is authorized to give or refuse consent to an intervention on behalf of a person who is incapable of making a decision with respect to the intervention. See Appendix I.

1. Informed Consent

Consent is an ongoing process and not a singular event. To be valid, consent must be informed. The Member has a duty to ensure the patient has sufficient information to make valid decisions about his/her care.

Performance Indicators

The Member ensures that consent is obtained prior to:

- obtaining a case history;
- performing a physical examination/testing;
- initiating treatment;
- collecting personal health information in accordance with the *Personal Health Information Protection Act, 2004.*

To be valid, consent:

- relates to the proposed intervention;
- is informed;
- is voluntary;
- is not obtained through fear, misrepresentation or fraud.

The Member appropriately documents the discussion in the patient chart. Patients need to understand and appreciate the reasonable foreseeable consequences of their decisions, in order to give informed consent.

The Member ensures that the patient or substitute decision-maker understands the following with respect to the proposed course of action:

- the nature of the intervention;
- its expected benefits;
- the material risks and side effects;
- available reasonable alternatives;
- the likely consequences of not receiving the intervention;
- any associated costs; and
- the right to withdraw consent.

The Member discloses risks or side effects that are likely to occur as well as risks and side effects that can result in significant harm or death even though they are unlikely to occur.

The Member answers questions or addresses any special concerns of the patient or substitute decision-maker.

The Member ensures that the patient or substitute decision-maker understands the professional status of those providing professional services.

2. Consent to Assessment and Treatment

The Member ensures that informed consent is obtained from the patient or substitute decision maker at the start of and throughout the assessment and treatment process.

Performance Indicators

The Member discusses the following with the patient or substitute decision-maker as appropriate:

- scope and reason for the assessment and treatment;
- associated costs;
- the purpose and nature of the assessment and treatment including whether information will be obtained from other individuals;
- the potential benefits and limitations of the assessment and treatment and the likely consequences of not receiving the intervention;
- the expected outcomes of the assessment and treatment;
- the right of the patient or substitute decision maker to withdraw consent at any time.

The Member:

- provides an opportunity for the patient or substitute decision maker to ask questions and responds to them in a manner that helps the patient or substitute decision-maker understand.

3. Determining Capacity

The Member when obtaining consent, ensures that the patient understands the information provided and is capable of giving consent to assessment and/or treatment.

Performance Indicators

The Member:

- Assumes that the patient is capable of providing consent, unless there is information that would lead the member to think otherwise;
- Considers factors that may indicate that the patient is incapable;
- Utilizes interpreters, if necessary, to ensure that the patient understands the consent process;
- When there is an indication to do so, follows a process to determine capacity:
    - Gathers objective and subjective information to determine the patient's capacity to give consent;
    - Analyzes the information gathered to determine the ability of the patient to make the required assessment and/or treatment decision;
    - Does not make presumptions of incapacity based on:
        - Diagnosis of a psychiatric or neurological condition;
        - Communication impairment;
        - Disability;
        - Refusal of intervention;
        - Age;
        - Acute or Chronic Health Status;
        - The fact that there is a guardian or substitute decision-maker in place
- Engages the patient in a collaborative approach regarding the capacity process;
- Upon determining incapacity, communicates to the patient the finding of incapacity, the reasons and his/her right of a review of this finding with the Consent and Capacity Board;
- Upon determining incapacity, takes reasonable measures to confirm the substitute decision-maker, and informs the patient that the substitute decision-maker will make the final decision related to the naturopathic services;
- Utilizes the hierarchy of substitute decision-makers (Appendix 1), if a substitute decision-maker has not been identified;
- Involves the patient in discussions with the substitute decision-maker whenever possible.

4. Record Keeping

The Member documents the consent process.

Performance Indicators

In addition to the College's Standard of Practice for Record Keeping, the Member documents:

- that a discussion regarding consent took place and the patient understands the proposed assessment or treatments and their risks, limitations and benefits;
- any modifications to the consent;
- when consent was obtained through the use of an interpreter, alternate means of communication, or a substitute decision maker; the identity of the interpreter or substitute decision maker, the legal entitlement of the

substitute decision maker as applicable (documentation on file, copy of Power of Attorney for personal care provided, etc.);

- that the patient withdrew consent, why he/she did so, and what specifically was withdrawn.

Documentation can take either of the following forms:

- a note in the patient record; and
- a consent form, that is dated, signed, and witnessed.

Related Standards

Acupuncture
Compounding
Dispensing
Fees and Billing
Inhalation
Injection
Internal Examinations
IV Infusion Therapy
Manipulation
Record Keeping

Legislative Framework

General Regulation
Health Care Consent Act, 1996
Personal Health Information Protection Act, 2004
Professional Misconduct Regulation

Approval

Original Approval Date: October 15, 2012

Latest Amendment Date: December 6, 2017

Disclaimer

In the event of any inconsistency between this standard and any legislation that governs the practice of Naturopathic Doctors, the legislation shall govern.

Appendix I

The Health Care Consent Act, 1996 defines the hierarchy of substitute decision-makers as:

- the incapable person's guardian if the guardian has authority to give or refuse consent to the treatment;
- the incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment;
- the incapable person's representative appointed by the Consent and Capacity Board if the representative has authority to give or refuse consent to the treatment;
- the incapable person's spouse or partner (which need not be a sexual partner);
- a child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This does not include a parent who has only a right of access and is not lawfully entitled to give or refuse consent to treatment. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent;
- a parent of the incapable person who has only a right of access;
- a brother or sister of the incapable person;
- any other relative of the incapable person;
- as a last resort, the Public Guardian and Trustee.

The College of Naturopaths of Ontario

Standard of Practice:

Record Keeping

Introduction

The intent of this standard is to advise Members with respect to the expectations for record keeping in their practice. This standard applies to both written and electronic records as appropriate.

Definitions

Patient Record: Consists of the patient chart, appointment record and financial records.

1. Appointment Records

The Member maintains an appointment record that is accurate, legible and comprehensive.

Performance Indicators

The Member maintains an appointment record that clearly and legibly identifies:

- Member's name, clinic name, address and telephone number;
- date and time of appointment;
- name of patient (minimum of last name and first initial); and
- duration of appointment.

The Member maintains and retains appointment records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

2. Patient Financial Records

The Member maintains a financial record that is accurate, legible and comprehensive.

Performance Indicators

The Member ensures that financial records clearly and legibly record:

- name of treating Member, clinic name, address, telephone number;
- patient's name, address and telephone number;
- date of service;
- services billed;
- substances, drugs or devices dispensed;
- payment amount and method of payment; and

- balance of account.

The Member ensures that:

- patient financial records are clearly itemized;
- fees for naturopathic consultation are separated from all other fees;
- fees for supplements, injectable substances, devices, special testing, etc., are individually listed;
- receipts are issued for all payments and copies are maintained in the patient financial record.

The Member maintains and retains financial records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

3. Patient Charts

The Member maintains a patient chart that is accurate, legible and comprehensive.

Performance Indicators

In all patient charts, the Member ensures:

- all written entries are made in indelible ink;
- the patient's name or patient number is recorded on each page;
- all entries are made in either English or French. Other languages may be used provided that English or French are also used;
- there is no highlighter used over writing;
- all written records are clearly legible;
- there are no blank spaces between entries;
- all pages are in chronological order, consecutively numbered and dated;
- a consistent format is used for recording the date;
- all chart entries are recorded as soon as possible after the patient interaction; and
- when other than generally accepted medical abbreviations are used, a legend of abbreviations or codes is available.

The Member ensures that all records contain:

- subjective information provided by the patient or their authorized representative;
- relevant objective findings;
- results of any naturopathic examinations;
- an assessment of the information and any diagnosis;
- proposed treatment plan, including prescriptions and recommendations;
- relevant communications with or about the patient;
- relevant information obtained from re-assessment; and
- indication of who made each entry and when the entry was made.

The Member records the following information related to the delivery of treatment:

- name and strength of all drugs and/or substances administered;
- dosage and frequency;
- date of administration;

- method of administration; and
- how treatment was tolerated.

The attending Member includes his/her registration number and signs the written record so that the treating ND is clearly identified.

The Member maintains and retains patient records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

4. Electronic Records

The Member ensures that electronic records are maintained and retained in a safe and effective manner.

Performance Indicators

The Member ensures that, when patient records are maintained in an electronic system, the following criteria are met:

- the system provides a visual display of the recorded information;
- the system provides a means of accessing the record of each patient by the patient's name;
- the system is capable of printing promptly the recorded information in chronological order for each patient;
- the system maintains an audit trail that:
    - records the date and time of each entry for each patient;
    - preserves the original content of the record if changed or updated;
    - identifies the person making each entry or amendment; and
    - is capable of printing each patient record separately.
- the system provides reasonable protection against unauthorized or inappropriate access;
- the system is backed up at least each practice day and allows for the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to and inaccessibility of records; and
- files are encrypted if they are transferred or transported outside of the facility.

5. Storage of Charts

When storing patient charts, the Member takes reasonable measures to ensure patient confidentiality and security of patient information to prevent unauthorized access and maintain its integrity.

Performance Indicators

The Member:

- ensures all patient charts are secured;
- ensures sensitive information is never left unattended in an unsecured location;
- stores all patient charts alphabetically or numerically, such that a specific file can be easily identified and retrieved;
- maintains a separate chart for each patient; and
- ensures, if other practitioners also see the same patient, that the Member's electronic records can be individually retrieved.

6. Amendments to Patient Charts

The Member ensures that any amendments made to a patient chart are properly documented.

Performance Indicators

The Member ensures that:

- any amendment to a written chart is initialed, dated and indicates what change was made;
- all previous written entries remain legible;
- amendments are only to be in the form of additions and not erasure or overwriting;
- the original entry is available and legible;
- a patient chart is never re-written.

7. Privacy

The Member adheres to the Personal Health Information Protection Act, 2004 (PHIPA).

Performance Indicators

The Member identifies the Health Information Custodian (HIC) who establishes written policies and procedures relating to the collection, use, and disclosure of all personal health information.

All patients are made aware that other practitioners may have access to their charts and patients may choose to decline that access.

8. Retention and Transfer of Patient Records

When retaining and transferring records, the Member takes reasonable measures to ensure confidentiality and security of information to prevent unauthorized access and maintain the record's integrity.

Performance Indicators

The Member:

- maintains the original chart unless it is requested by the College for a regulatory purpose or is required for legal purposes in which case a copy is retained by the Member;
- never provides any information concerning a patient to a person other than the patient or their authorized representative(s) without the express consent of the patient, an authorized representative, or as otherwise required by law;
- may charge a reasonable fee to reflect the actual cost of reproduction, the time required to prepare the material and the direct cost of sending the material to the authorized party. The Member shall not require prepayment of this fee. Non-payment of the fee is not a reason for the Member to withhold the information;
- retains and transfers records in a manner that ensures continued access by patients and the College.

The Member maintains and retains records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

In the event of the death of a Member, the responsibility for the maintenance of the records lies with the estate, which is obliged to maintain those records as defined above. If the estate sells the practice to another Member, all records are transferred to the purchasing Member and are maintained as above.

If a Member relocates a practice he/she takes the patient records to the new location. If the practice ceases operation, the Member either appropriately transfers or maintains the original of all patient records as described above. Patients are notified in writing as to how they can obtain access to their patient records. The College is also notified and provided with a forwarding address for a minimum of ten (10) years.

In the event of a sale of the practice, all of the original records are transferred to the purchasing Member who maintains those records as described above. Where feasible (in some cases by newspaper notice) patients are notified, in writing, of the practice sale so that any patient who requires it may obtain a copy of their record. The College is also informed in writing of the sale and in whose care and control the original records will be maintained.

In all cases, the College is notified, in writing, of the forwarding address where the records are kept for a minimum of ten (10) years from the date of the last day of practice of the Member. Any records that are destroyed after the minimum period of retention are destroyed by shredding, burning, overwriting software or some other method to render them illegible and irretrievable. The Member maintains a record of disposal dates and the names of patients whose records were disposed.

9. Dispensing and Selling of Drugs and Substances

The Member creates and maintains appropriate records of the dispensing and selling of drugs and substances for a minimum of ten years.

Performance Indicators

The Member:

- records and maintains an inventory of drugs and substances purchased or received, including date of receipt;
- records the date drugs and substances are dispensed and/or sold;
- records the name of the person to whom the drugs and substances were dispensed and/or sold;
- maintains copies of prescriptions/recommendations from other Members or health care providers;
- maintains a log containing a record of distribution of each drug or substance dispensed to enable the Member to issue a recall of any dispensed drug or substance;
- maintains a record of any product recalls or alerts provided by the manufacturer or Health Canada; and
- maintains these records for a minimum of ten (10) years.

10. Equipment Records

The Member creates and maintains appropriate records of the purchase, maintenance and disposition of clinical equipment.

Performance Indicators

The Member:

- records and maintains an inventory of equipment purchased or received, including date of receipt;
- records the date and nature of service or maintenance on equipment;
- records the date of disposition of equipment;
- maintains these records for a minimum of five (5) years.

Related Standards

Consent
Dispensing
Fees and Billing

Prescribing
Recommending Non-Scheduled Substances
Selling

Legislative Framework

Personal Health Information Protection Act, 2004
Professional Misconduct Regulation

Disclaimer
In the event of any inconsistency between this standard and any legislation that governs the practice of Naturopathic Doctors, the legislation shall govern.

The College of Naturopaths of Ontario

Standard of Practice:

Record Keeping

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Performance Indicators

The Member maintains an appointment record that clearly and legibly identifies:

- Member's name, clinic name, address and telephone number;
- date and time of appointment;
- name of patient (minimum of last name and first initial); and
- duration of appointment.

The Member maintains and retains appointment records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

2. Patient Financial Records

The Member maintains a financial record that is accurate, legible and comprehensive.

Performance Indicators

The Member ensures that financial records clearly and legibly record:

- name of treating Member, clinic name, address, telephone number;
- patient's name, address and telephone number;
- date of service;
- services billed;
- substances, drugs or devices dispensed;
- payment amount and method of payment; and

- balance of account.

The Member ensures that:

- patient financial records are clearly itemized;
- fees for naturopathic consultation are separated from all other fees;
- fees for supplements, injectable substances, devices, special testing, etc., are individually listed;
- receipts are issued for all payments and copies are maintained in the patient financial record.

The Member maintains and retains financial records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

3. Patient Charts

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Performance Indicators

In all patient charts, the Member ensures:

- all written entries are made in indelible ink;
- the patient's name or patient number is recorded on each page;
- all entries are made in either English or French. Other languages may be used provided that English or French are also used;
- there is no highlighter used over writing;
- all written records are clearly legible;
- there are no blank spaces between entries;
- all pages are in chronological order, consecutively numbered and dated;
- a consistent format is used for recording the date;
- all chart entries are recorded as soon as possible after the patient interaction; and
- when other than generally accepted medical abbreviations are used, a legend of abbreviations or codes is available.

The Member ensures that all records contain:

- the patient's chief complaint(s);
- relevant health, family and social history;
- subjective information provided by the patient or their authorized representative;
- relevant objective findings;
- consent;
- results of any naturopathic examinations;
- an assessment of the information and any diagnosis;
- proposed treatment plan, including prescriptions and recommendations;
- relevant communications with or about the patient;
- the patient's reactions/feedback to treatment
- relevant information obtained from re-assessment;
- relevant referral and consultation information, where applicable; and
- indication of who made each entry and when the entry was made.

The Member records the following information related to the delivery of treatment:

- name and strength of all drugs and/or substances administered;
- dosage and frequency;
- date of administration;
- method of administration; and
- how treatment was tolerated.

The attending Member includes his/her registration number and signs the written record so that the treating ND is clearly identified.

The Member maintains and retains patient records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

4. Electronic Records

The Member ensures that electronic records are maintained and retained in a safe and effective manner.

Performance Indicators

Electronic records are subject to the same security requirements as paper/written information. The Member ensures that, when patient records are maintained in an electronic system, the following criteria are met:

- the system provides a visual display of the recorded information;
- the system provides a means of accessing the record of each patient by the patient's name or other unique identifier;
- the system is capable of printing the recorded information in chronological order for each patient;
- the system maintains an audit trail that:
    - records the date and time of each entry for each patient;
    - preserves the original content of the record if changed or updated;
    - identifies the person making each entry or amendment; and
    - is capable of printing each patient record separately.
- the system provides reasonable protection against unauthorized or inappropriate access;
- the system is backed up at least each practice day and allows for the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to and inaccessibility of records;
- backed-up files are stored in a physically separate and secure area; and
- files are encrypted if they are transferred or transported outside of the facility.

When making the transition from paper to electronic records, the Member must:

- ensure the integrity of the data that has been converted into electronic form;
- verify that documents have been properly scanned;
- ensure that the entire patient record is intact upon conversion, including all attached notes and hand-written comments.

5. Storage of Charts

When storing patient charts, the Member takes reasonable measures to ensure patient confidentiality and security of patient information to prevent unauthorized access and maintain its integrity.

Performance Indicators

The Member:

- ensures all patient charts are secured;
- ensures sensitive information is never left unattended in an unsecured location;
- stores all patient charts alphabetically or numerically, such that a specific file can be easily identified and retrieved;
- maintains a separate chart for each patient; and
- ensures, if other practitioners also see the same patient, that the Member's electronic records can be individually retrieved.

6. Amendments to Patient Charts

The Member ensures that any amendments made to a patient chart are properly documented.

Performance Indicators

The Member ensures that:

- any amendment to a written chart is initialed, dated and indicates what change was made;
- all previous written entries remain legible;
- amendments are only to be in the form of additions and not erasure or overwriting;
- the original entry is available and legible;
- a patient chart is never re-written.

7. Privacy

The Member adheres to the Personal Health Information Protection Act, 2004 (PHIPA).

Performance Indicators

The Member obtains the patient's consent when collecting, using or disclosing personal health information unless provided otherwise by law.

The Member maintains patient confidentiality in the course of collecting, storing, using, transmitting and disposing of personal health information.

The Member identifies the Health Information Custodian (HIC) who establishes written policies and procedures relating to the collection, use, and disclosure of all personal health information. The patient is informed of who has custody and control of their personal health information and how their information will be managed.

All patients are made aware that other practitioners may have access to their charts and patients may choose to decline that access.

8. Retention and Transfer of Patient Records

When retaining and transferring records, the Member takes reasonable measures to ensure confidentiality and security of information to prevent unauthorized access and maintain the record's integrity.

Performance Indicators

The Member:

- maintains the original chart unless it is requested by the College for a regulatory purpose or is required for legal purposes in which case a copy is retained by the Member;
- never provides any information concerning a patient to a person other than the patient or their authorized representative(s) without the express consent of the patient, an authorized representative, or as otherwise required by law;
- may charge a reasonable fee to reflect the actual cost of reproduction, the time required to prepare the material and the direct cost of sending the material to the authorized party. The Member shall not require prepayment of this fee. Non-payment of the fee is not a reason for the Member to withhold the information;
- retains and transfers records in a manner that ensures continued access by patients and the College.

The Member maintains and retains records for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry.

In the event of the death of a Member, the responsibility for the maintenance of the records lies with the estate, which is obliged to maintain those records as defined above. If the estate sells the practice to another Member, all records are transferred to the purchasing Member and are maintained as above.

If a Member relocates a practice he/she takes the patient records to the new location. If the practice ceases operation, the Member either appropriately transfers or maintains the original of all patient records as described above. Patients are notified in writing as to how they can obtain access to their patient records. The College is also notified and provided with a forwarding address for a minimum of ten (10) years.

In the event of a sale of the practice, all of the original records are transferred to the purchasing Member who maintains those records as described above. Where feasible (in some cases by newspaper notice) patients are notified, in writing, of the practice sale so that any patient who requires it may obtain a copy of their record. The College is also informed in writing of the sale and in whose care and control the original records will be maintained.

In all cases, the College is notified, in writing, of the forwarding address where the records are kept for a minimum of ten (10) years from the date of the last day of practice of the Member

9. Dispensing and Selling of Drugs and Substances

The Member creates and maintains appropriate records of the dispensing and selling of drugs and substances for a minimum of ten years.

Performance Indicators

The Member:

- records and maintains an inventory of drugs and substances purchased or received, including date of receipt;
- records the date drugs and substances are dispensed and/or sold;
- records the name of the person to whom the drugs and substances were dispensed and/or sold;

- maintains copies of prescriptions/recommendations from other Members or health care providers;
- maintains a log containing a record of distribution of each drug or substance dispensed to enable the Member to issue a recall of any dispensed drug or substance;
- maintains a record of any product recalls or alerts provided by the manufacturer or Health Canada; and
- maintains these records for a minimum of ten (10) years.

10. Disposing of Patient Records

The Member does not dispose of a record of personal health information unless their obligation to retain the record has come to an end.

Performance Indicators

When the obligation to retain records comes to an end, the records may be destroyed:

- paper or hard copy records must be disposed of in a secure manner such that the reconstruction of the record is not reasonably possible;
- Electronic records must be permanently deleted from all hard drives, as well as other storage mechanisms.
    - Hard drives must either be crushed or wiped clean with a commercial disk wiping utility.
    - Similarly, any back-up copies of the records must be destroyed.

The Members maintains a record of disposal dates, and names of patient whose records were disposed.

Related Standards

Consent
Dispensing
Fees and Billing
Prescribing
Recommending Non-Scheduled Substances
Selling

Legislative Framework

Personal Health Information Protection Act, 2004
Professional Misconduct Regulation

Approval

Original Approval Date: October 15, 2012
Latest Amendment Date: March 6, 2019.

Disclaimer

In the event of any inconsistency between this standard and any legislation that governs the practice of Naturopathic Doctors, the legislation shall govern.

The College of Naturopaths of Ontario

Standard of Practice

Scope of Practice

Introduction

The intent of this standard is to advise Members with respect to the expectations concerning Members as providers of naturopathic services and as responders to general health-related questions.

Definitions

Act: means the *Naturopathy Act, 2007*.

Controlled Act: means any diagnostic or therapeutic procedure listed in section 27(2) of the Regulated Health Professions Act (RHPA) that is authorized to certain regulated health professionals in providing patient care.

DPRA: means the *Drug and Pharmacies Regulation Act, 1990.*

Public Domain: means any diagnostic or therapeutic procedure other than those listed in section 27(2) of the RHPA that any regulated health professional may utilize in the course of providing care.

RHPA: means the *Regulated Health Professions Act, 1991.*

1. Scope of Practice

The practice of naturopathy is the assessment of diseases, disorders and dysfunctions and the naturopathic diagnosis and treatment of diseases, disorders and dysfunctions, using naturopathic techniques to promote, maintain, or restore health.

2. Controlled Acts

In the course of engaging in the practice of naturopathy, a Member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. *Putting an instrument, hand or finger beyond the labia majora but not beyond the cervix.*
2. *Putting an instrument, hand or finger beyond the anal verge but not beyond the rectal-sigmoidal junction.*
3. *Administering, by injection or inhalation, a prescribed substance.*
4. *Performing prescribed procedures involving moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.*
5. *Communicating a naturopathic diagnosis identifying, as the cause of an individual's symptoms, a disease, disorder or dysfunction that may be identified through an assessment that uses*

naturopathic techniques.

6. *Taking blood samples from veins or by skin pricking for the purpose of prescribed naturopathic examinations on the samples.*

7. *Prescribing, dispensing, compounding or selling a drug designated in the regulations.*

3. Diagnostic and Therapeutic Procedures

A Member shall take reasonable steps to ensure that any proposed diagnostic or therapeutic procedure to be used for the benefit of a patient relates to the naturopathic scope of practice.

In order to perform a diagnostic or therapeutic procedure, a Member shall:

- *achieve, maintain and be able to demonstrate clinical competency (e.g., examination, certification, or proof of training) in the diagnostic or therapeutic procedure.*

A Member shall obtain the patient's consent to the use of the diagnostic or therapeutic procedure, consistent with Standard of Practice for Informed Consent, that is:

- *fully informed;*
- *voluntarily given;*
- *related to the patient's condition and circumstances;*
- *not obtained through fraud or misrepresentation; and*
- *evidenced in a written form signed by the patient or otherwise documented in the patient health record.*

If a proposed diagnostic or therapeutic procedure does not fall within the naturopathic scope of practice and the knowledge, skill and judgment of a member, a Member should not use the diagnostic or therapeutic procedures in their professional capacity.

4. Responding to General Health-Related Questions

A Member is restricted from treating or advising outside the naturopathic scope of practice, when it is reasonably foreseeable that serious bodily harm may result by section 30 (1) of the RHPA as follows:

> *30 (1) No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious bodily harm may result from the treatment or advice or from an omission from them.*

In responding to general health-related questions by patients that relate to controlled acts outside the naturopathic scope of practice (such as questions relating to a drug as defined in the DPRA not authorized to the profession, performing surgery and administering vaccinations), a member shall:

- *Advise the patient that the performance of the act is outside the naturopathic scope of practice and refer the patient to a health professional who has the act within his/her scope of practice;*
- *Respond in a professional, accurate and balanced manner in the context of providing primary health care to the patient consistent with the naturopathic scope of practice; and*
- *Encourage the patient to be an active participant in his/her own health care which allows the patient to make fully informed decisions concerning his/her health care.*

5. Offences

40 (1) Every person who contravenes subsection ... 30 (1) is guilty of an offence and on conviction is liable,

- *(a) for a first offence, to a fine of not more than $25,000, or to imprisonment for a term of not more than one year, or both; and*
- *(b) for a second or subsequent offence, to a fine of not more than $50,000, or to imprisonment for a term of not more than one year, or both.*

6. Mandatory Referral

A member is required under Ontario Regulation 168/15 to make a referral to another regulated health professional under the following circumstances:

1. *If a patient's life is or may be at risk, it is a standard of practice of the profession that the member shall immediately call emergency services to transfer the patient to a hospital.*

2. *If the patient's condition prevents the member from communicating a naturopathic diagnosis because the condition is beyond the scope of practice of the profession, it is a standard of practice of the profession that the member shall refer the patient to,*
    a) *a member of the College of Physicians and Surgeons of Ontario;*
    b) *a member of the College of Nurses of Ontario who holds a certificate of registration as a registered nurse in the extended class; or*
    c) *a member of a another health profession College where the patient's condition would fall within that member's scope of practice under his or her health profession Act.*

3. *If treatment of the patient's condition is beyond the scope of practice of the profession, it is a standard of practice of the profession that the member shall refer the patient to,*
    a) *a member of the College of Physicians and Surgeons of Ontario;*
    b) *a member of the College of Nurses of Ontario who holds a certificate of registration as a registered nurse in the extended class; or*
    c) *a member of another health profession College where the patient's condition would fall within that member's scope of practice under his or her health profession Act.*

4. *If the treatment of the patient's condition requires diagnostic, monitoring or treatment related technology that is beyond the scope of practice of the profession, it is a standard of practice of*

the profession that the member shall refer the patient to,

a) *a member of the College of Physicians and Surgeons of Ontario; or*
b) *a member of another health profession College where the diagnostic, monitoring or treatment related technology would fall within that member's scope of practice.*

5. *If the patient or the patient's authorized representative asks the member to refer the patient to another member or a member of another health profession College, it is a standard of practice of the profession that the member shall immediately make the referral in accordance with the request of the patient or his or her authorized representative.*

6. *It is a standard of practice of the profession that the member must immediately refer the patient to a member of the College of Physicians and Surgeons of Ontario or a member of the College of Nurses of Ontario who holds a certificate of registration as a registered nurse in the extended class if the patient's laboratory test result from a laboratory licensed under the Laboratory Specimen Centre Collection Licensing Act is a critical value test result.*

7. *It is a standard of practice of the profession that the member must refer the patient to a member of the College of Physicians and Surgeons of Ontario or a member of the College of Nurses of Ontario who holds a certificate of registration as a registered nurse in the extended class if the response of a patient to the treatment offered by a member is not adequate and is not likely to improve based on alternative treatments available from the member, or if the patient's condition significantly deteriorates and is likely to continue to do so without a referral.*

7. Implications of Failure to Comply

A member is reminded that they may be the subject of an inquiry, complaint or report concerning the provision of naturopathic services or discussions related to general health-related questions from patients.

The Inquiries, Complaints and Reports Committee (ICRC), composed of elected (naturopath), appointed (public) and non-council (naturopath) committee members will review any inquiry, complaint or report to determine the member's compliance with all regulations and relevant standards of practice including this policy.

In exercising its discretion, the ICRC may consider if the discussions with the patient relating to general health-related questions were consistent with this policy, the regulations and standards of practice of the profession.

8. Legislative Context

In addition to the legislative provisions outlined above, members are reminded that the following are acts of professional misconduct under Ontario Regulation 17/14 (Professional Misconduct):

1. Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic or other health-

related purpose except,

- *i. with the informed consent of the patient or the patient's authorized representative, or*
- *ii. as required or authorized by law.*

4. Failing to reveal the exact nature of a substance or treatment used by the member following a request by a patient or a patient's authorized representative to do so.

7. Recommending or providing treatment that the member knows or ought to know is unnecessary or ineffective.

8. Providing or attempting to provide services or treatment that the member knows or ought to know to be beyond the member's knowledge, skill or judgment.

9. Failing to advise a patient or the patient's authorized representative to consult another member of a health profession within the meaning of the Regulated Health Professions Act, 1991, when the member knows or ought to know that the patient requires a service that the member does not have the knowledge, skill or judgment to offer or is beyond his or her scope of practice.

10. Performing a controlled act that the member is not authorized to perform.

11. Performing a controlled act that was delegated to the member by another person unless the member has the knowledge, skill and judgment to perform the controlled act.

23. Failing to keep records in accordance with the standards of the profession.

26. Making a claim respecting a drug, substance, remedy, treatment, device or procedure other than a claim that can be supported as reasonable professional opinion.

27. Permitting the advertising of the member or his or her practice in a manner that is false or misleading or that includes statements that are not factual and verifiable.

36. Contravening, by act or omission, a provision of the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts.

37. Contravening, by act or omission, a law if,

- *i. the purpose of the law is to protect or promote public health, or*
- *ii. the contravention is relevant to the member's suitability to practise.*

48. Failing to make reasonable attempts to collaborate with the patient's other relevant health care providers respecting the care of the patient, where such collaboration is necessary for the patient's health, unless the patient refuses to consent.

Related Standards

Communicating a Diagnosis
Compounding
Consent
Dispensing
Fees and Billing
Injection

Internal Examinations
Intravenous Infusion Therapy
Performing Authorized Acts
Prescribing
Record Keeping
Recommending Non-Scheduled Substances
Selling

Legislative Framework

Naturopathy Act, 2007
Professional Misconduct Regulation
General Regulation
Regulated Health Professions Act, 1991
Drug and Pharmacies Regulation Act, 1990
Health Care Consent Act, 1996

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The College of Naturopaths of Ontario

Standard of Practice:

Therapeutic Relationships and Professional Boundaries

Introduction

The intent of this standard is to advise Members on how to establish and maintain appropriate therapeutic relationships and professional boundaries with patients.

Definitions

Mandatory Report: Under the *Regulated Health Professions Act, 1991,* it is mandatory that a report be made by a regulated health professional who, in the course of practicing his/her profession, acquires information leading to reasonable grounds to believe that another regulated health care professional sexually abused a patient.

Family Member: For the purpose of this standard, "family member" means a Naturopathic Doctor's spouse or partner, parent, child, sibling, grandparent or grandchild; a parent, child, sibling, grandparent or grandchild of the Naturopathic Doctor's spouse or partner.

Close Personal Relationship: For the purpose of this standard, "close personal relationship" means a relationship in which the Naturopathic Doctor has personal or emotional involvement with an individual that may render the Naturopathic Doctor unable to exercise objective professional judgment in reaching diagnostic or therapeutic decisions.

Minor Condition: Generally, a non-urgent, non-serious condition that requires only short-term routine care and is not likely to be an indication of, or lead to, a more serious condition.

Emergency: Exists where an individual is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if intervention is not promptly provided.

1. Appropriate Therapeutic Relationships and Boundaries

The Member fosters appropriate therapeutic relationships with his/her patients in a transparent, ethical, patient-centred manner with respect for diversity of beliefs, values and interests.

Performance Indicators

The Member:

- recognizes the position of power the Member has over the patient within the therapeutic relationship;
- does not exploit these relationships for any form of non-therapeutic or personal gain, benefit or advantage;
- never enters into a sexual relationship with a current patient or someone with whom the patient has a significant personal relationship (e.g., child's parent);
- does not enter into a sexual relationship with a former patient unless it can be reasonably established that sufficient time has elapsed since the professional relationship ended or was terminated and it can be demonstrated that there is no longer a power imbalance between the Member and the patient;

- never enters into a sexual relationship with a former patient where counselling was a significant part of treatment;
- does not enter into a therapeutic relationship and/or accept a patient with whom the Member already has a personal relationship and where professional boundaries may not be sustained;
- takes immediate steps to address and rectify a boundary violation when it occurs; and
- accepts responsibility for boundary crossings and violations when they occur.

2. Consent

The Member understands that patient consent is never a defence against a boundary violation.

Performance Indicators

The Member:

- develops and maintains practices and procedures to explain to the patient that consent does not permit a non-therapeutic relationship or allow for a personal relationship with the patient; and
- when appropriate, clearly and diplomatically explains why patient consent does not justify a boundary violation.

3. Personal Relationships

The Member does not provide naturopathic services to his/her own family members or another individual with whom they have a close personal relationship except for minor conditions or in the event of an emergency.

Performance Indicators

The Member:

- maintains practices and procedures that clearly demonstrate that provision of naturopathic services to an individual with whom the Member has a personal relationship may be inappropriate as outlined in legislation and/or if professional boundaries may not be sustainable;
- clearly, sensitively and consistently explains why the service cannot be provided; and
- does not treat a person with whom they are having a sexual relationship, except in an emergency.

Related Standards and Guidelines

Consent
Internal Examinations
Conflict of Interest

Legislative Framework

Professional Misconduct Regulation
Regulated Health Professions Act, 1991
College of Naturopaths of Ontario Patients Relations Program

Disclaimer

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COLLEGE OF NATUROPATHS OF ONTARIO - and - KURT STAUFFERT

DISCIPLINE COMMITTEE OF THE
COLLEGE OF NATUROPATHS OF ONTARIO

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